STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105523	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Port Rehabilitation and Nursing Center	6940 Outreach Way North Port, FL 34287

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on record review, resident representative and staff interviews, the facility failed to promote the residents' rights to be involved in medication management, including being informed of the risks and benefits for use of psychotropic medications for 1 (Resident #20) of 5 residents reviewed for unnecessary medication use. The findings included: Review of the clinical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included history of Bipolar Disorder, Anxiety, Major Depressive Disorder, Unspecified Mood Disorder, Dementia with behavioral disturbance, and Confusional Arousal. The Admission Minimum Data Set (MDS) dated [DATE] (Federally mandated assessment to evaluate the health and functional capabilities of residents) noted Resident #20's cognition was severely impaired with a Brief Interview for Mental Status Score of 07. The MDS noted the resident was displaying verbal (threatening others, screaming at others, cursing at others) and physical behavioral symptoms (hitting, kicking, pushing, scratching, grabbing) directed toward others one to three days. Review of the physician's orders and the Medication Administration Record (MAR) for April 2024, May 2024 and July 2024 revealed Resident #20 was administered the following psychotropic medications: Buspirone HCL 10 mg (milligrams) one tablet by mouth two times a day for antianxiety from 4/25/24 to 4/30/24. (Discontinued on 4/30/24). Depakote 125 mg one tablet by mouth two times a day for bipolar disorder from 4/26/24 through 5/5/24. (Discontinued on 5/5/24). Depakote 125 mg one tablet by mouth two times a day related to unspecified mood (affective) disorder from 5/11/24. Haloperidol 1 mg one tablet by mouth two times a day for antipsychotics/antimanic agents one dose on 4/25/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Haloperidol (antipsychotic) 2 mg one tablet by mouth two times a day for behavior from 4/25/24 to 5/5/24. (Discontinued on 5/5/24). Risperdal (antipsychotic) 0.5 mg one tablet by mouth two times a day for bipolar with mania and agitation from 4/30/24 to 5/5/24. (Discontinued on 5/5/24). Risperdal 1 mg one tablet by mouth in the morning for Parkinson's with agitation and anxiety from 6/7/24 through 7/12/24 (Discontinued on 7/12/24). Risperdal 0.5 mg one tablet at bedtime for Parkinson's with behavioral mood and agitation on 6/6/24 through 7/12/24 (Discontinued on 7/12/24). Risperdal 1 mg one tablet by mouth two times a day for Parkinson's with agitation and anxiety starting on 7/12/24. Seroquel 50 mg one tablet by mouth two times a day for major depressive disorder, recurrent on 4/27/24 and 4/28/24. (Discontinued on 4/28/24). Seroquel 100 mg one tablet three times a day related to Bipolar Disorder on 4/28/24 through 5/3/24. (Discontinued on 5/3/24). Alprazolam 0.25 mg one tablet by mouth every eight hours as needed for anxiety for 14 days one dose on 4/25/24 and 4/26/24. (Discontinued on 4/26/24). Alprazolam 0.5 mg one tablet by mouth every eight hours as needed for anxiety for 14 days, one does on 4/27/24, 4/29/24 and 4/30/34 (Discontinued on 5/5/24). Alprazolam 0.5 mg orally every 8 hours as needed for agitation, one dose given on 7/5/24, 7/10/24, 7/14/24, 7/17/24, and two doses on 7/7/24. Haloperidol lactate 5mg per ml, 10 mg IM on 4/27/24 related to unspecified mood disorder. Haloperidol lactate 5mg per milliliter (ml), 5 mg intramuscularly (IM) on 4/28/24, and 4/30/24. The care plan initiated on 4/25/24 noted Resident #20 uses antipsychotic medications related to behavior management, diagnosis of depression. The interventions included to educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms as indicated. Review of the electronic medical record showed no documentation Resident #20 or resident representative were informed of the treatment, risks and benefits related to the use of the psychotropic medications. On 7/15/24 at 2:38 p.m., in an interview Resident #20's Daughter-in-Law said she nor her husband were informed Resident #20 was receiving multiple psychotropic medications and were not informed of the risks or benefits related to the psychotropic medications. She said no one told them about Resident #20's behaviors and the multiple Haldol injections. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 1:11 p.m., in an interview the Administrator and the Director of Nursing (DON) verified Resident #20 was not capable of making informed decisions regarding her medical decisions. The DON said Resident #20's son and daughter-in-law were involved in her care. Multiple requests were made to the Director of Nursing on 7/16/24 at 1:11 p.m., 7/17/24 at approximately 11:00 a.m., and on 7/18/24 at approximately 10:30 a.m., to provide documentation Resident #20 and her family were involved in the medication management process, informed of the risks and benefits and consented to the use of psychotropic medications. As of 7/18/24 the DON failed to provide the requested information.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50649 Based on record review and interview, the facility failed to ensure 1(Resident #39) of 3 sampled residents reviewed received the Skilled Nursing Advance Beneficiary of Non-coverage (CMS-10123) to inform the resident of potential liability for payment and related standard claim appeal rights. The findings included: Review of Resident #39's census data information revealed Resident #39's services in the facility were covered by Medicare Part A, effective 11/17/2023. Review of Resident #39's coverage notice records revealed a Notice of Medicare Non-Coverage form that documented Resident #39's skilled nursing services would end on 2/13/24. Review of the Beneficiary Protection Notification Review form completed by the Minimum Data Set Coordinator revealed the facility initiated Resident #39's discharge from Medicare Part A Services with benefit days remaining. Review of Resident #39's coverage notice records failed to reveal any documentation that Resident #39 had been provided with the Skilled Nursing Advance Beneficiary of Non-Coverage notice (CMS-10123). On 7/18/24 at10:45 a.m., in an interview the Admissions Coordinator stated, We have a corporate resource who is like a case worker who helps us if the Resident has an unusual plan or something. She stated the facility would get the formed signed denoting the conversation occurred with the Resident or responsible party but was unable to provide the signed form for Resident #39.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on Observation, interview, and record review the facility failed to provide maintenance services to ensure a clean, safe, and comfortable environment in the residents' designated smoking area and 1 (Rosebud unit) of 1 unit observed with stained ceiling tiles, and 2 (Rooms #134 and #176) of 60 rooms observed. The findings included: On 7/14/24 at 9:26 a.m., a nursing staff member was observed wiping condensation from the air conditioner vent near the Rosebud Nursing station. Eleven of the ceiling tiles around the vent showed signs of leaking from the ceiling. An area of black growth was observed on the wall near the ceiling next to the rosebud nursing station. On 7/15/24 at 11:00 a.m., in an interview the Regional Manager of Operations said the roof was leaking. On 7/11/24 an inspector came out and was working on obtaining an estimate for the necessary repairs. She provided documentation from a roofing company describing the damage found to the roof on 7/11/23. She stated a lot of what was seen on the tiles is from condensation from the air conditioning. The Regional Manager of operations verified the black growth on the wall near the nursing station and said she was not made aware of the black organic growth on the wall. On 7/18/24 11:20 a.m., the Director of Maintenance said the facility was working on a quote to fix the roof and address the condensation on the air conditioning vents. On 7/14/24 at 1:52 p.m., in an interview Resident #6 said the tent which was the designated smoking area in the courtyard had been leaking. The resident said when it rains and they are out smoking, they get wet. On 7/17/24 at 2:19 p.m., observation of the designated smoking area in the courtyard showed the tent had a large opening directly down the middle of the roof that extended the entire length of the roof line. On 7/18/24 at 11:20 a.m., in an interview the Director Of Maintenance said he found out the tent was leaking on 7/17/24. The maintenance Director said nursing staff were supposed to use the facility's electronic system to document areas in need of repair. The Director Of Maintenance said staff needed to be instructed to enter maintenance issues in the system to ensure repairs are completed in a timely manner. On 7/14/24 at 11:20 a.m., the door to the closet next to the window in room [ROOM NUMBER] was observed in disrepair. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/24 at 11:20 a.m., the Director of Maintenance verified the closet needed to be repaired but no one had informed him of the damage to the closet door in room [ROOM NUMBER]. 38570 On 7/14/24 at 10:32 a.m., during an observation into the shared bathroom of room [ROOM NUMBER] noted on the back of the toilet there were two (2) urinals and two (2) wash basins. The items were not noted to have either resident name or room number and bed. An emesis basin was also noted to be sitting on the side of the sink with a toothbrush and toothpaste in it. These items were also not labeled with resident name or room number and bed. room [ROOM NUMBER] was occupied by two residents at the time of the observation. On 7/15/24 at 8:54 a.m., during a second observation into bathroom in room [ROOM NUMBER] the resident personal items of two (2) urinals and two (2) wash basins on the back of the toilet with no labeling observed. The 2-wash basin were different colors on pink and one was light gold. they were sitting in one another. The urinal were tucked behind the wash basins. The Emesis basin was also still on the counter beside the sink with no noted labeling as to which resident it belonged to. the sink had a cabinet below it and it had 2 door on it, but the doors had no knobs to open the cabinet to put items below the sink. On 7/17/24 at 3:10 p.m., during a third observation of the bathroom in room [ROOM NUMBER] accompanied by LPN Staff L, again we observed the 2 urinals and 2 wash basins on the back of the toilet and the emesis basin still did not have labeling on it as to which resident it belonged to. During an interview on 7/17/24 at 3:11 p.m., LPN Staff L verified the personal items in room [ROOM NUMBER] were not labeled making it impossible to know which resident they belonged to. During an interview on 7/18/24 at 1:06 p.m. Director of Nursing (DON) said the residents personal items kept in their bathrooms should be labeled with their name and room number and bed and kept separate from the other persons things in the room. DON states that like in the cabinet below the sink, one resident items she be on one side and the others on the other side and labeled. DON said that if items are found commingled together without being labeled they should be thrown away and the resident given new ones. She said what the surveyor found was cross contamination.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on record review, resident family and staff interviews, the facility failed to ensure the Baseline Care Plan (BCP) was provided to the resident and their representative with a summary of the baseline care plan that included but was not limited to the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and any updated information for 1 (Resident #94) of 3 residents reviewed for BCP. The findings included: Review of Resident #94's medical record revealed she was admitted to the facility on [DATE] with admission diagnoses of altered mental status, hypertension, muscle weakness, open wound of lower leg, and paroxysmal tachycardia. The Admission Nursing Evaluation dated 1/3/24 stated the BCP was reviewed by the Interdisciplinary Team (IDT) and Other, and a copy of the BCP and medication reconciliation were offered to the resident/representative/family member. The nurse also documented they had discussed the physician orders, treatment, plan of care, medications and discharge planning with the resident and/or responsible party. On 7/16/24 at 8:53 a.m., in an interview with the Minimum Data Set (MDS) Coordinator, she said the admitting nurse was responsible to complete each resident's BCP within 48 hours and was required to provide the resident and/or their representative or family a copy of the BCP which included the initial goals, a summary of the resident's medications and dietary instructions, any services and treatments in progress and any updated information. She said no residents and/or their families were provided a copy of the baseline care plan during their care plan conference attended by the resident and/or their family and the IDT which was held no later than 28 days after the resident was admitted to the facility. The MDS Coordinator confirmed Resident #94 was admitted to the facility on [DATE] and the admitting nurse documented she had completed the BCP on 1/3/24 and provided a copy to the resident/representative/family. The MDS Coordinator said Resident #94's initial admission care plan meeting was held on 2/8/24 and she was unable to find documentation Resident #94's Power of Attorney (POA) was given a copy of Resident #94's BCP as required. On 7/16/24 at 10:00 a.m., in an interview with Staff R, a Registered Nurse (RN), she said she had worked at the facility for 1.5 years. She said when a resident was admitted to the facility, the admitting nurse was required to complete the BCP which was part of the Admission Nursing Evaluation. She said nursing was not required to give a copy to the resident and/or their family. Staff R stated she believed the MDS office was required to provide a copy of the BCP to the resident and/or their representative/family. On 7/16/24 at 10:10 a.m., in an interview with Staff L, Unit Manager, she said she had worked at the facility for over 6 years. She said the admission nurse was responsible for completing the BCP in the Admission Nursing Evaluation within 48 hours of the resident being admitted to the facility. She said the MDS office was required to provide a copy of the BCP to the resident and/or family member. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 10:30 a.m., in an interview with Resident #94's daughter, she said her mother was admitted to the facility on [DATE] due to cognitive decline and was deemed incompetent prior to her admission to the facility. She said she was Resident #94's POA and the facility had not told her or provided her with her mother's admitting diagnoses, medication list and/or other pertinent information. She said neither she nor her brother were offered and/or provided a copy of Resident's BCP. On 7/16/24 at 11:04 a.m., in an interview with the Director of Nursing, she confirmed Resident #94 was admitted to the facility on [DATE] with a primary diagnosis of altered mental status and Resident #94's daughter is Resident #94's POA. The DON also confirmed Resident #94's admitting nurse documented in the Admission Nursing Evaluation, dated 1/3/24, she had completed the BCP on 1/3/24 and offered a copy to the resident/representative/family member. The Admission Nursing Evaluation did not identify who was offered a copy of the BCP whether it be the resident, their representative or the family member. The Admission Nursing Evaluation noted the BCP was reviewed with the IDT and Other but did not include the Resident/Representative/Family Member or the Physician/Physician's Assistant (PA)/Advance Practice Registered Nurse (APRN). The DON said she was unable to find documentation the nursing department had provided Resident #94's daughter (her POA) a copy of Resident #94's BCP with the required information within 28 days of admission to the facility as required per federal regulation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on observation, interview and record review the facility failed to provide the necessary care and services to maintain personal hygiene for 3 (Residents #20, #33, and #167) of 8 sampled residents dependent on staff for activities of daily living, including showers, incontinent care and nail care. The findings included: 1. Record review revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included history of Bipolar Disorder, Anxiety, Major Depressive Disorder, Unspecified Mood Disorder, Dementia with behavioral disturbance, Confusional Arousal, Congestive Heart Failure, Chronic Kidney Disease, Anemia, and Hypertension. The Admission Minimum Data Set (MDS) assessment dated [DATE] noted Resident #20's cognition was severely impaired with a Brief Interview for Mental Status (BIMS) score of 07. The assessment noted Resident #20 was dependent on staff for personal hygiene. On 7/15/24 at 9:28 a.m. Resident #20 was observed lying in the bed. Resident #20's left hand was contracted. Resident #20 was not able to open her left hand. The resident's fingernails to the right and left hand were long and extended approximately 1/2 inch with an accumulation of a brown substance under the nails. On 7/17/24 at 9:47 a.m., in an interview Certified Nursing Assistant (CNA) Staff T said activities staff were responsible for residents nail care. On 7/17/24 at 9:49 a.m., in an interview Licensed Practical Nurse (LPN) Staff H said the activities staff were responsible for residents' nail care. Staff H said the CNAs can also clip fingernails as needed. On 7/18/24 at 10:00 a.m., the Acting Director of Rehabilitation was observed working with Resident #20 and trying to open her left hand. In an interview, the Director verified Resident #20's nails were long and dirty. The Director said the resident's nails needed to be clipped to prevent them from digging into her left hand, and cleaned. On 7/18/24 at 10:40 a.m., during a joint observation the Director of Nursing (DON) verified Resident #20's nails needed to be clipped and cleaned. The DON said the CNAs were responsible to clip the resident's nails and keep them clean. 2. Review of the clinical record for Resident #33 revealed an admitted [DATE] with a history of Dementia. The Quarterly MDS dated [DATE] noted the resident's cognition was severely impaired. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan revealed Resident #33 had self-care deficit with Activities of Daily Living (ADLs) related to activity intolerance. The resident's ADL needs and participation varied. The interventions noted the resident was dependent on staff for bathing needs, including transfer into and out of shower. On 7/15/24 at 3:54 p.m., in an interview Resident #33's daughter said she found her mother in the hallway today soaked through with urine and feces. She said this happens all the time and she spoke to the administration. Resident #33's daughter said she had spoken with the administration verbally about the issue and it keeps happening. Resident #33's daughter said her mother does not receive showers regularly. She said her mother suffered a bacterial infection on her face because staff were not bathing her regularly. Review of the bathing history revealed Resident #33 received a total of three showers (6/22/24, 7/3/24 and 7/13/24) from 6/19/24 through 7/13/24. On 7/17/24 at 11:20 a.m., in a telephone interview CNA Staff U she said she worked at the facility until May 2024. Staff U said residents were being left soaked in urine and caked in feces. They were always short-staffed at night and she would be assigned 20 to 25 residents at night. Staff U said when she brought up her concerns to the DON and the Administrator at the time she was told to forget about it. It was not that important. She stated she felt leaving residents unchanged would cause skin breakdown and she could no longer work for the facility. On 7/17/24 at 1:35 p.m., in an interview LPN Staff I said the last couple nights CNAs have complained about the workload, they have 25 patients. Staff I said she's had CNAs complain during the morning change of shift that residents are soaked through with urine, and had to completely change the bedding of four residents as they were soaked through with urine. On 7/18/24 at 10:55 a.m., in an interview the Director of Nursing said Resident #33's daughter had not reported any care concerns to her. She said she would have written the verbal complaint as a grievance. 25618 3. On 7/14/24 at 1:39 p.m., in an interview with Resident #167 and Resident #167's husband, they said Resident #167 had not received a shower since being admitted to the facility on [DATE]. Resident #167 said she had asked the facility staff multiple times if they could assist her with a shower but they keep telling her she had to wait until her shower day to receive her shower and get her hair washed. Resident #94's husband said he would assist his wife with her shower if he could, but his wife is unsteady on her feet, and he didn't want her to fall. They said the nursing staff promised to give her a shower tonight. On 7/15/24 at 1:46 p.m., in an interview with Resident #94 and Resident #94's granddaughter, they said the nursing staff did not give Resident #94 her shower on 7/13/24 as promised. The granddaughter said she had to give her grandmother a shower and wash her hair on the afternoon of 7/15/24 with assistance from one of the nursing staff. Resident #94 said she felt a lot better now that she had a shower and was able to get her hair washed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #94's medical record revealed she was admitted to the facility on [DATE] with diagnosis of polyneuropathy, low back pain, polyarthritis, syncope and collapse and a need for assistance with personal care. The Nail Care and Shower Schedule revealed Resident #94's showers are due every Wednesday and Saturday morning. Review of Resident #94's shower documentation noted Resident #94 had not received her scheduled showers on 7/3, 7/6, 7/10, and 7/13 as required. Further review of Resident #94's medical record revealed no documentation Resident #94 had refused her scheduled showers on 7/3, 7/6, 7/10, and 7/13. On 7/17/24 at 11:43 a.m., in an interview with Staff L, Unit Manager, she said all residents were scheduled for a shower 2 times a week, and the resident's Certified Nursing Assistant (CNA) were required to give the resident their shower as scheduled. She said if a resident refused their shower, the CNA was required to inform the resident's nurse. If the resident continued to refuse their shower, the CNA and nurse were required to document the refusal in the resident's medical record. She said the facility has a dedicated CNA who assisted with the resident's schedule shower each day, but it was the resident's assigned CNA who was responsible to ensure their resident received their scheduled shower each day. On 7/17/24 at 11:55 a.m., interview with Staff T, CNA, he said he was the assigned CNA to do the resident's daily shower. He said he had 18 to 20 resident showers to do each day. He said if he was assigned to another task because the facility is low on staff and/or a CNA had called off for that day, he was unable to do the resident showers and resident assigned CNA for that day was responsible to complete their resident scheduled shower for that day. Staff T said he had not given Resident #94 a shower since she was admitted to the facility. He said Resident #94 was cooperative and would not refuse care and/or a shower if it had been offered to her. On 7/17/24 at 12:19 p.m., in an interview with Staff L, Unit Manager, she confirmed after she reviewed Resident #94's medical record that Resident #94 had not received her scheduled showers on 7/3, 7/6, 7/10, and 7/13 as required, and she was unable to find the required documentation why Resident #94 had not received her required scheduled showers.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on review of the clinical record, review of facility policy and procedures and staff interviews, the facility failed to have documentation of blood sugar results as ordered for 1(Resident #53) of 1 resident reviewed with diabetes. The findings included: The facility policy Physician Orders issued 1/1/23 documented All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. Review of the clinical record revealed Resident #53 had a readmitted [DATE] with diagnoses including stage 3 chronic kidney disease and type 2 diabetes. The physician orders included to inject Lantus insulin, 10 units subcutaneously at bedtime. The physician's orders dated 1/16/24 read, May obtain finger-stick blood sugar twice daily. Notify physician for results < (less than) 60 and > (greater than) 300. Review the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for April 2024, May 2024, June 2024 and July 2024 showed each day at 9:00 a.m., and 9:00 p.m., the nurses placed a check mark and their initials on the MAR indicating the blood sugar via finger-stick was obtained. The MARs did not document the blood sugar results for each finger-stick. Review of the electronic blood sugar summary for Resident #53 from 1/16/24 through 7/17/24 showed the following blood sugar results: On 2/21/24 at 10:08 p.m., 241 milligrams per deciliter (mg/dl). On 7/15/24 at 9:27 p.m., 156 mg/dl. On 7/16/24 at 5:28 a.m.,132 mg/dl. On 7/16/24 at 9:22 p.m., the blood sugar was 333 mg/dl. There was no documentation the physician was notified of the blood sugar result greater than 300 mg/dl as specified in the physician's order dated 1/16/24. On 7/17/24 at 5:38 a.m., 135 mg/dl. No other blood sugar results were documented in the clinical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 1:08 p.m., in an interview Licensed Practical Nurse (LPN) Staff I said all documentation is put into the computer system, we have no paper documents. The only time we would use paper is if the computer system has gone down. The LPN said for blood sugars the computer prompts the nurse to enter the blood sugar result and the amount of insulin provided for sliding scale. The results can be entered manually in the system, and if they are just getting blood sugar monitoring you can do that too, you put your initials and then put in the blood sugar. Staff I confirmed the facility did not record the blood sugar results on paper. On 7/18/24 at 1:22 p.m., in an interview Registered Nurse Staff J said, blood sugars are documented in the computer system only, there is no paper charting here, no paper charts. Everything is documented in the computer system. On 7/15/24 multiple requests were made to the Director of Nursing for documentation of blood sugar results for Resident #53 from 1/16/24 through 7/15/24 but the requested documentation was not provided. On 7/15/24 at 1:54 p.m., the facility obtained a new physician's order that read, Obtain finger-stick blood sugar twice daily. Notify physician for results < 60 or >300 two times a day for hypoglycemia.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46824 Based on interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for 1 (Resident #418) of 1 sampled resident receiving dialysis. The findings included: 1. The facility policy and procedure titled, Standards and Guidelines: Dialysis Care, with an effective date of 10/2014 and a revision date of 1/2024, stated the facility will implement individualized plans of care to include the interdisciplinary team as well as the dialysis care team in coordination with the attending physician. The Procedure included, Correspondence from the dialysis center will be addressed by facility staff and will be recorded in the plan of care as indicated; The facility will provide a snack/meal to the resident per request prior to or after dialysis appointment . Review of the clinical record revealed Resident #418 was admitted to the facility on [DATE]. Diagnoses included End Stage Renal Disease (ESRD), Hypertension (HTN), Anemia and Infrarenal abdominal aortic aneurysm. The physician's orders included hemodialysis (treatment to filter wastes and water from the blood) at a local dialysis center every Monday, Wednesday and Friday related to ESRD. Review of Resident #418's dialysis patient's information form titled, Tracking my numbers for June 2024 noted the plan for the month was, You need more protein now that you are on dialysis. The form noted the Albumin (Protein in the blood that helps fight infections and aids in healing) was 3.5. The goal was 4 or higher. The physician's orders dated 6/19/24 specified large protein portions for diet. On 6/24/24 the facility's Registered Dietitian documented in a nutritional evaluation Resident #418 may benefit from additional protein-rich foods per the diagnosis of ESRD dependence on hemodialysis three times a week. The intervention was to, Initiate large protein portions. Review of the laboratory results dated [DATE] showed the resident's albumin level was 3.5 for a reference range of 3.5 to 5.2 gram per deciliter. On 7/3/24 the Registered Dietitian (RD) from the dialysis center documented in a communication form to the facility Resident #418's albumin was 3.5. Under special instructions the RD documented to Please add daily protein supplement. The clinical record lacked documentation that a daily protein supplement was added to the resident's diet as requested by the Registered Dietitian. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 12:43 p.m., in a telephone interview the facility's Regional Registered Dietitian said she could not locate documentation showing the intervention to add large protein portions to the resident's diet had been effective. On 7/18/24 at 2:40 p.m., Licensed Practical Nurse (LPN) Staff G said she asked the Director of Nursing (DON) who verified the lack of documentation that a daily protein supplement was added to the resident's diet. 2. The facility policy Medication Administration (Revised 1/2024) documented Medications are administered in accordance with prescriber orders, including any required time frame . Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so . Medications errors are documented, reported, and reviewed by the QAPI [Quality Assurance and Performance Improvement] committee to inform process changes and the need for additional training . If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall document the rational in the resident's medical record and notify the physician and the responsible party if indicated . Review of the physician's orders revealed Resident #418's medications regimen included: Nifedipine ER extended release 24-hour 60 mg once daily for high blood pressure; Metoprolol 25 mg give 2 tablets by mouth two times a day for high blood pressure. Renvela oral tablet 800 mg, take two tablets three times a day with meals for control of phosphorus levels. Omeprazole capsule 40 mg give one capsule by mouth one time a day for infrarenal abdominal aortic aneurysm ruptured. Review of the Medication Administration Record (MAR) for June 2024 and July 2024 showed the scheduled 9:00 a.m. Metoprolol was not documented as administered on 6/19/24, 6/21/24, 6/28/24, 7/1/24, 7/3/24, 7/5/24, 7/8/24, 7/12/24, and 7/15/24. The scheduled 9:00 a.m. dose of Nifedipine ER 60 mg was not documented as administered on 6/19/24, 6/21/24, 6/24/24, 6/28/24, 7/1/24, 7/2/24, 7/3/24, 7/8/24, 7/12/24 and 7/15/24. The scheduled 9:00 a.m. dose of Renvela 800 mg was not documented as administered on 6/19/24, 6/21/24, 6/24/24, 6/28/24, 7/1/24, 7/2/24, 7/3/24, 7/4/24, 7/5/24, 7/8/24, 7/10/24, 7/12/24 and 7/15/24. On 7/16/24 at 8:29 a.m., in an interview Resident #418 said on dialysis days, the facility does not provide him with breakfast or lunch on dialysis days. He said they give him a diet drink which he doesn't like. Resident #418 said, Sometimes I have a protein bar. The resident verified the facility did not provide him with the Renvela to take with his food at the dialysis center. The scheduled 9:00 a.m. dose of Omeprazole was not documented as administered on 6/24/24, 6/28/24, 7/1/24, 7/2/24, 7/3/24, 7/4/24,7/5/24, 7/8/24, 7/10/24, 7/12/24, and 7/15/24. In addition, the MAR lacked documentation physician's ordered daily Aspirin, Nephro-Vite, and Zinc were administered as scheduled at 9:00 a.m. on dialysis days. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/24 the physician issued an order for Resident #418 for Vitamin D3, Give 2000 IU by mouth one time a day for Vitamin D3, result 38.1. The MAR for July 2024 lacked documentation the Vitamin D3 was administered on Friday 7/12/24 and Monday 7/15/24. On 7/17/24 at 8:59 a.m., in an interview Registered Nurse (RN) Staff J said she was assigned to Resident #418. Staff J verified Resident #418 did not get his morning medications on dialysis days when he's out of the building. RN Staff J said she has not notified the physician his orders were not followed and Resident #418 did not receive the ordered medications on dialysis days. On 7/17/24 at 9:41 a.m., in an interview the Director of Nursing said she was not aware Resident #418 was not receiving the physician's ordered medications on dialysis days. She said the medication administration time should be changed on dialysis days, and the medications can also be given at dialysis. She said any nurse could call the physician, get an order and make the changes. The Administrator was present during the interview.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on observation, interview and record review the facility failed to provide sufficient staffing to ensure 6 residents of 40 residents surveyed (#3, #14, #20 #33, #58, and #65) received appropriate ADL care and ensured call lights were answered in a timely manner. The findings included: On 7/15/24 at 11:47 a.m. Resident #3 said she waits an hour for staff to respond to her call light. Last night I was up all night because any time I had to urinate I would have to wait an hour to get back to bed. The aide came in and said what do you want I explained I needed wiped and assisted back to bed by lifting my legs. The aide wiped me and left the room. I put my light back on and she came back and said what do you want I explained I needed someone to lift my legs in the bed. The aide told me she had other things to do. She said she had to tell her it would only take a minute for her to lift her legs. She said it is hard when the aid does not know what you need. On 7/15/24 at 1:20 p.m. Resident #65 said when she uses her call light it takes a long time for staff to respond. She said the 11 p.m. to 7 a.m. shift is the worst. On 7/16/24 at 10:54 a.m. an emergency call light was observed sounding an alarm. Resident #58 was observed in the hallway waving his hands above his head summoning for help. Licensed Practical Nurse, Staff H came to the nurse's station and looked at the red beeping light on the emergency panel above her and sat down to chart at the computer. Resident #58's room alarm was sounding for 7 minutes and 47 seconds before a Certified Nursing Assistant walked by and assisted the resident to the bathroom. On 7/16/24 at 11:06 a.m. Resident #58 said he had put his call light on because he had to use the bathroom, Resident #58 said he waited for 15 minutes, and he had a bowel movement and had to urinate. Resident #58 said there was no one for him to talk to about the issue. The resident said if staff would come when I ask, I could make it to the bathroom. Resident #58 was asked how he felt, and he said it made him feel horrible. On 7/16/24 1:30 p.m., the Unit manager said all call lights should be responded to within 5-10 minutes. All Staff should be answering call lights. On 7/18/24 at 9:54 a.m. Licensed Practical Nurse, Staff H, said Resident #14 keeps turning his light on. Staff H said Resident #14 thinks he is the only one here. Staff H said, I go in and ask what do you want and he says I want my aide. Staff H said, I told him she will come at 10:30 a.m. but it doesn't sink in sometimes. The light keeps ringing, we go by and say to him motel 6 the light is always on. At that time a Certified Nursing Assistant came to nurse's station and told Staff H Resident #14 requested to see the nurse or the head nurse regarding his call light not being answered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #20 is a [AGE] year-old female who was admitted to the facility on [DATE] with a history of Bipolar Disorder, Anxiety, Major Depressive Disorder, Unspecified Mood Disorder, Dementia with behavioral disturbance, Confusional Arousal, Congestive Heart Failure, Chronic Kidney Disease, Anemia, and Hypertension. On 7/15/24 at 2:37 p.m. in a telephone interview Resident #20's daughter said when she visits her mother they use the call light to her get up or change her brief. She said after 10 to 15 minutes she would have to stand in the hallway and try to flag a staff member down. On 7/15/24 at 9:28 a.m. Resident #20 was observed lying in the bed. Resident #20's left hand was observed to have contractures and to be unable to open her hand. The resident's fingernails on both hands were long and dirty. On 7/17/24 at 9:47 a.m. Certified Nursing Assistant (CNA), Staff T said activities staff was responsible to do nail care on the residents. On 7/17/24 at 9:49 a.m. Licensed Practical Nurse, Staff H said activities was responsible to do nail care on the residents. Staff H said the aides can clip nails as well if needed. On 7/18/24 at 10:00 a.m., The Acting Director of Rehabilitation was observed working with the resident to open her left hand. The Director verified Resident #20's nails were long and dirty. The Director said the resident had to have her nails clipped and cleaned to prevent them from digging into her left hand. On 7/18/24 at 10:40 a.m. The Director of Nursing (DON) Observed the resident's nails and verified they needed clipped and cleaned. The DON said the CNAs were responsible to clip the resident's nails and keep them clean. Review of the clinical record for Resident #33 revealed an admitted [DATE] with a history of Dementia. The Quarterly MDS dated [DATE] noted the resident's cognition was severely impaired. Review of the care plan revealed Resident #33 had self-care deficit with Activities of Daily Living (ADLs) related to activity intolerance. The resident's ADL needs and participation varied. The interventions noted the resident was dependent on staff for bathing needs, including transfer into and out of shower. On 7/15/24 at 3:54 p.m., in an interview Resident #33's daughter said she found her mother in the hallway today soaked through with urine and feces. She said this happens all the time and she spoke to the administration. Resident #33's daughter said she had spoken with the administration verbally about the issue and it keeps happening. Resident #33's daughter said her mother does not receive showers regularly. She said her mother suffered a bacterial infection on her face because staff were not bathing her regularly. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the bathing history revealed Resident #33 received a total of three showers (6/22/24, 7/3/24 and 7/13/24) from 6/19/24 through 7/13/24. On 7/17/24 at 11:20 a.m., in a telephone interview CNA Staff U she said she worked at the facility until May 2024. Staff U said residents were being left soaked in urine and caked in feces. They were always short-staffed at night and she would be assigned 20 to 25 residents at night. Staff U said when she brought up her concerns to the DON and the Administrator at the time she was told to forget about it. It was not that important. She stated she felt leaving residents unchanged would cause skin breakdown and she could no longer work for the facility. On 7/17/24 at 1:35 p.m., in an interview LPN Staff I said the last couple nights CNAs have complained about the workload, they have 25 patients. Staff I said she's had CNAs complain during the morning change of shift that residents are soaked through with urine, and had to completely change the bedding of four residents as they were soaked through with urine.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46824 Based on observation, review of facility's policies and procedures, and staff interviews the facility failed to ensure 4 (Residents #4, #63, #67 and #418) of 5 sampled residents were free from significant medication errors. The findings included: The facility policy Medication Administration (Revised 1/2024) documented Medications are administered in accordance with prescriber orders, including any required time frame . Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so . Medications errors are documented, reported, and reviewed by the QAPI [Quality Assurance and Performance Improvement] committee to inform process changes and the need for additional training . If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall document the rational in the resident's medical record and notify the physician and the responsible party if indicated . 1. On 7/15/24 at 11:43 a.m., observation of the medication cart of the rose bud unit with Licensed Practical Nurse (LPN) Staff S revealed several pills in two unlabeled plastic medication cups. One cup had three pills which LPN Staff S said were Resident #4's Carvedilol 6.25 milligrams (mg) (Blood pressure medication), Eliquis 2.5 mg (anticoagulant) and Hydroxyzine 25 mg (antianxiety). The cup was stored on an alcohol wipe labeled with Resident #4's name. LPN Staff S said the medications were scheduled to be given at 8:00 a.m. Photographic evidence obtained. Review of the clinical record for Residents #4 revealed a physician's order for Carvedilol 6.25 mg to be administered two times a day for high blood pressure. The morning dose of Carvedilol was scheduled to be administered at 8:00 a.m. The physician's order for Eliquis 2.5 mg specified to administer one tablet by mouth two times a day for atrial fibrillation (type of irregular heart rate). The morning dose of Eliquis was scheduled to be administered at 8:00 a.m. In an interview during the observation, LPN Staff S verified he did not administer the Carvedilol and the Eliquis within the required time frame. One cup had seven pills which LPN Staff S identified as Midodrine 2.5 mg (to treat low blood pressure), Eliquis 2.5 mg, Oxcarbazepine 150 mg, Tylenol 325 mg (2 tablets) for pain and Gabapentin 300 mg (two tablets) for neuropathy. LPN Staff S said the medications belonged to Resident #63 and were scheduled to be administered at 8:00 a. m. The medication cup was stored on an alcohol pad labeled with Resident #63's name. Photographic evidence obtained. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the clinical record for Resident #63 revealed a physician's order dated 4/8/24 to administer Midodrine 2.5 mg, one tablet by mouth in the morning for hypotension (low blood pressure) and Midodrine 5 mg, one tablet by mouth at bedtime. The morning dose of Midodrine was scheduled to be administered at 8:00 a.m. The physician's order for Eliquis 2.5 mg specified to administer one tablet by mouth two times a day for a history of DVT (Deep Vein Thrombosis). The morning dose of the Eliquis was scheduled to be administered at 8:00 a.m. The physician's order for Oxcarbazepine specified to administer one tablet by mouth two times a day for mood disorder. The morning dose of Oxcarbazepine was scheduled to be given at 8:00 a.m. The physician's order specified to administer Gabapentin 300 mg, two capsules by mouth three times a day for neuropathy (nerve pain). The medication was scheduled to be administered at 8:00 a.m., 1:00 p.m., and 5:00 p.m. LPN Staff S verified he did not administer the medications to Resident #63 within the required time frame. 3. On 7/15/24 at 2:04 p.m., Resident #67 was observed in bed. She appeared very upset. She said she did not know the nurse who was on duty today. He was trying to trick her and give her pills that she already took. Resident #67 said she always takes her morning medications with her breakfast and never in the afternoon. A medication cup with five pills was observed unsecured on the resident's bedside table. On 7/15/24 at 2:15 p.m., in an interview LPN Staff S verified he left the cup of medications unattended at the resident's bedside. LPN Staff S said he got behind with his medication administration and the medication cup contained the resident's morning medications which were scheduled to be given at 9:00 a.m. LPN Staff S said the medications left at bedside included Ferrous Sulfate, Gabapentin, Labetalol, and Keppra. Review of the Medication Administration Audit report revealed Resident #67's physician's orders included: Ferrous Sulfate 325 mg, give one tablet by mouth two times a day for supplementation medication with meals. Gabapentin capsule 100 mg, give one capsule by mouth two times a day for pain. Labetalol HCL oral tablet 200 mg, give one tablet by mouth two times a day for hypertension (High blood pressure). Keppra tablet 250 mg, give 1.5 tablet by mouth two times a day for seizure. The morning dose of Ferrous Sulfate, Gabapentin, Labetalol, and Keppra were scheduled to be administered at 9:00 a.m. The administration time documented was 2:17 p.m., 5 hours and 17 minutes beyond the scheduled time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER: North Port Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 6940 Outreach Way North Port, FL 34287	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the clinical record for Resident #418 revealed an admitted [DATE]. Diagnoses included End Stage Renal Disease (ESRD), and Hypertension. The physician's orders included hemodialysis (treatment to filter wastes and water from the blood) every Monday, Wednesday and Friday related to ESRD at a local dialysis center. The physician's ordered medications included: Nifedipine ER extended release 24-hour 60 mg once daily for high blood pressure; Metoprolol 25 mg give 2 tablets by mouth two times a day for high blood pressure. Ranvela oral tablet 800 mg, take two tablets three times a day with meals for control of phosphorus levels. Omeprazole capsule 40 mg give one capsule by mouth one time a day for infrarenal abdominal aortic aneurysm ruptured Review of the Medication Administration Record (MAR) for June 2024 and July 2024 showed on dialysis days (Mondays, Wednesdays and Fridays) the scheduled 9:00 a.m. Metoprolol was not documented as administered on 6/19/24, 6/21/24, 6/28/24, 7/1/24, 7/3/24, 7/5/24, 7/8/24, 7/12/24, and 7/15/24. The scheduled 9:00 a.m. dose of Nifedipine ER 60 mg was not documented as administered on 6/19/24, 6/21/24, 6/24/24, 6/28/24, 7/1/24, 7/2/24, 7/3/24, 7/8/24, 7/12/24 and 7/15/24. The scheduled 9:00 a.m. dose of Ranvela 800 mg was not documented as administered on 6/19/24, 6/21/24, 6/24/24, 6/28/24, 7/1/24, 7/2/24, 7/3/24, 7/4/24, 7/5/24, 7/8/24, 7/10/24, 7/12/24 and 7/15/24. The scheduled 9:00 a.m. dose of Omeprazole was not documented as administered on 6/24/24, 6/28/24, 7/1/24, 7/2/24, 7/3/24, 7/4/24,7/5/24, 7/8/24, 7/10/24, 7/12/24, and 7/15/24. On 7/16/24 at 8:29 a.m., in an interview Resident #418 said he goes to dialysis on Mondays, Wednesdays and Fridays. The resident said he leaves the facility around 5:30 a.m. and returns at approximately 2:00 p.m. Resident #418 said no one checks his blood pressure before he goes to dialysis and he does not get his morning medications on dialysis days. On 7/17/24 at 8:59 a.m., in an interview Registered Nurse (RN) Staff J said she was assigned to Resident #418. Staff J verified Resident #418 did not get his morning medications on dialysis days when he's out of the building. RN Staff J said she has not notified the physician his orders were not followed and Resident #418 did not receive the ordered medications on dialysis days. On 7/17/24 at 9:41 a.m., in an interview the Director of Nursing said she was not aware Resident #418 was not receiving the physician's ordered medications on dialysis days. She said the medication administration time should be changed on dialysis days, and the medications can also be given at dialysis. She said any nurse could call the physician, get an order and make the changes. The Administrator was present during the interview. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER North Port Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6940 Outreach Way North Port, FL 34287	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/24 at 10:04 a.m., in a telephone interview the Advanced Practice Registered Nurse said the standard protocol is for the provider to be notified of any missed or late medication, and document in the record. She said she would have wanted to be informed of the missed medications for Residents #4, #63, #67 and #418.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46824 Based on observation and interview, the facility failed to store medications in a safe, secure manner for 3 (Residents # 67, #4, and #63) of 3 residents reviewed for medication storage. The findings included: Medication Storage and Labeling policy issued 3/2021 and Revised 1/2024 said Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles . Procedure noted Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received . The nurse staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. On 7/14/24 at 11:11 a.m., Resident #67 was observed in bed. Nystatin powder and multiple pills were noted in a medicine cup on her breakfast tray. Resident #67 stated the nurse leaves these here so I can take them with my breakfast. Photographic documentation obtained. On 7/15/24 at 2:04 p.m., a medication cup with five pills was observed unsecured on Resident #67's bedside table. In an interview Resident #67 said the nurse was trying to trick her into taking the medications she already took that morning. On 7/15/24 at 2:15 p.m., in an interview LPN Staff S verified he left the medications unattended at the resident's bedside. On 7/15/24 at 11:43 a.m., observation of the medication cart on the rose bud unit with Licensed Practical Nurse (LPN) Staff S revealed several pills in two unlabeled plastic medication cups placed on an alcohol wipe packet. One alcohol wipe was labeled with Resident #4's name and the other wipe was labeled with Resident #63's name. In an interview LPN Staff S said the cup with the three pills were Resident #4's morning medications and contained the resident's Carvedilol 6.25 milligrams (mg) (Blood pressure medication), Eliquis 2.5 mg (anticoagulant) and Hydroxyzine 25 mg (antianxiety). Photographic evidence obtained. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN Staff S said the other cup contained seven pills and were Resident #63's morning medications including, Midodrine 2.5 mg (to treat low blood pressure), Eliquis 2.5 mg, Oxcarbazepine 150 mg, Tylenol 325 mg (2 tablets) for pain and Gabapentin 300 mg (two tablets) for neuropathy. Photographic evidence obtained. LPN Staff S verified the medications were not labeled and stored in accordance with the facility's policy and procedures. He said they should have been discarded when not administered to the residents on time.